

5-42  
5-17-39  
X327

31713

State File No. \_\_\_\_\_

ED SEP 25 1943  
Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 724

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Rural, S. Campbell Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Ozark Osteopathic Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Day  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Lula Marie York

3. (b) If veteran, name war none  
3. (c) Social Security No. none

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Ernest Eugene York  
6. (c) Age of husband or wife if alive 17 years

7. Birth date of deceased October 17 - 1925  
(Month) (Day) (Year)

8. AGE: Years 17 Months 10 Days 14  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Pulaski Co Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Evert Pickerson

13. Birthplace unk. Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Nellie York (deceased)

15. Birthplace unk. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant husband, E.E. York

(b) Address Waynesville, Mo.

17. (a) Burial (b) Date thereof Sept. 3, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Waynesville, Mo.

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 9-1-43 (b) Dr. W.S. Handley  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pulaski  
(c) City or town Waynesville  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 31st year 1943 hour 4:15 minute 30 a.m.

21. I hereby certify that I attended the deceased from Aug - 31 1943 to Sept 1, 1943  
that I last saw her alive on Sept 1, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Septicemia (acute)  
Due to Chronic renal disease  
Due to Pregnancy (periperal)  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Duration

PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W.S. Handley M.D. or other \_\_\_\_\_  
Address Springfield, Mo. Date signed Sept 1, 1943

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *L. Pauline Forman*

Licensed Embalmer No. *3177*

P. O. Address *Springfield Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

*7*

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. out

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Osark Osteopathic Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether

In this community \_\_\_\_\_ years, months or days) (Specify whether

3. (a) PRINT FULL NAME Lula M. York  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct. 17 - 1926  
(Month) (Day) (Year)

8. AGE: Years 17 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pulaski  
(c) City or town Waynesville  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 1943 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Respiritis Acute  
cardiac renal disease  
Due to Pregnancy (Preperal)  
normal child born about  
Due to one month previous.

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

23. Signature William H. H. H. (M. D. or other) \_\_\_\_\_  
Address Springfield Mo Date signed Oct 15, 43

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

MAR 8 194

31713